GUIDELINES FOR THE MANAGEMENT OF COMMON MEDICAL RETINAL CONDITIONS IN EYE CASUALTY

DIABETIC RETINOPATHY

1. **Proliferative diabetic retinopathy**

If a patient with known PDR(PRP done in past) is seen in eye casualty with new onset of decreased vision due to vitreous haemorrhage then patient needs urgent PRP + anti-VEGF. An urgent laser slot had been created in each routine PM laser list for retinopexy/PRP. Please find out if urgent PRP can be arranged in this slot over the next few days from Medical retina booking team. If no slot available then please discuss with Medical retina Consultant/fellow. Also leave the notes in the medical retina tray in Eye Casualty INDICATING PATIENTS MEDICAL RETINA CONSULTANT IN CHARGE and the fact that patient NEEDS URGENT PRP+anti-VEGF. Urgent fax to LOCAL MEDICAL RETINA UNIT informing them about this episode and to arrange further follow up. Fax to be done by Eye Casualty admin staff.

If the vitreous haemorrhage is dense with poor fundal view and a retinal tear or detachment cannot be excluded then a B scan should be performed on the same day. Consider referral to VR service depending on the B-scan findings. If retina is flat and no urgent VR intervention required then forward notes to the consultant in charge or LOCAL EYE UNIT.

URGENT PRP MANAGEMENT (Same day PRP)

1. **New vessels on the iris** (Rubeosis iridis; NVI)

a) NVI with normal IOP - **same day** PRP (aim for 1500 spots) and inform Medical retina fellow /Consultant for urgent intravitreal Avastin (within a week) and further management.

b) NVI with high IOP - All of the above + Inform Glaucoma fellow / Consultant.

Please also refer to Rubeotic Glaucoma guidelines.

2. **High-risk proliferative diabetic retinopathy** -

NVD ≥ one-third of disc area; any amount of NVD with vitreous or preretinal haemorrhage; NVE ≥ to one-half disc area with preretinal or vitreous haemorrhage.

3) PDR in pregnancy.

If patient has had no previous PRP then perform **same day** PRP (aim for 1500 spots) and confirm from CDA Consultant in charge for the patient. Inform the Consultant / Medical retina fellow.

2. **Diabetic Macular Oedema**

If patient with known DMO (already having anti-VEGF/steroid injection) is seen in Eye Casualty with new onset symptoms related to worsening DMO then *please* find out Consultant in charge for the patient and forward notes to them. If patient is not from BMEC/SGH then Urgent FAX to LOCAL MEDICAL RETINA UNIT informing them about this episode. It is good practice to grade non-PDR using 4-2-1 rule so Consultant can determine urgency of the referral.

THERE IS NO NEED FOR OCT FOR ANY DIABETIC RETINOPATHY PATIENTS IN EYE CASUALTY AS IT WILL NOT CHANGE THE PATIENT'S MANAGEMENT ON THE DAY.

SUSPECTED CHOROIDAL NEOVASCULAR MEMBRANES

1. New referral from OPTICIAN - Send referral to Medical Retina Office for FAST TRACK MACULAR CLINIC appointment in 2 weeks
2. First presentation with Massive haemorrhage and suspected CNVM. VR opinion to consider any surgical intervention (tPA +gas). Also send referral to Medical Retina Office for FAST TRACK MACULAR CLINIC appointment in 2 weeks
3. Known case of CNVM from any aetiology with new onset distortion - Send notes to Consultant in charge or LOCAL UNIT for further review.

CENTRAL RETINAL ARTERY OCCLUSION

Check BP & BM. Urgent FBC, ESR and CRP to exclude giant cell arteritis for all patients with CRAO.

If onset within 24 hours, Give IV 500mg acetazolamide stat + ocular massage + air bag rebreathing. Consider AC paracentesis after discussing risks and benefits with the patient.

If longer duration since onset, use own judgement as benefit of intervention unlikely to change outcome.

Patients with CRAO need referral to TIA service or same day referral to Main A&E. The urgency is dictated by the ABCD2 score. Referral forms are available in Eye A&E. If any queries, discuss with Medical Registrar on call at Sandwell Hospital (bleep number available via Switchboard).

BRANCH RETINAL ARTERY OCCLUSION

Same management principles to be followed as CRAO. Patients with BRAO also need referral to TIA service as above.
GCA is extremely rare as a cause of BRAO and does not require investigation unless there are other features of GCA. However, strongly consider GCA in BRAO setting in the presence of cilioretinal artery occlusion.

Perform Topcon OCT (Both horizontal and vertical line scans to document Inner retinal layer swelling). It is important to ascertain and document the extent of involvement at presentation as most clinical retinal findings disappear in a few weeks.

CENTRAL AND BRANCH RETINAL VEIN OCCLUSION

Check BP and BM in Eye Casualty

Check IOP and for RAPD. Clinically differentiate Ischaemic from Non-ischaemic CRVO

Check for rubeosis

1. New referral from OPTICIAN - Send referral to Medical Retina Office for FAST TRACK VEIN OCCLUSION CLINIC appointment.
2. Known case of RVO with new symptoms - send notes to Consultant in charge or LOCAL EYE UNIT for further review except if patient presents with rubeosis then manage as advised in URGENT PRP MANAGEMENT section.

THERE IS NO NEED FOR OCT FOR ANY CRVO/BRVO PATIENTS IN EYE CASUALTY AS IT WILL NOT CHANGE PATIENT'S MANAGEMENT ON THE DAY.

CENTRAL SEROUS CHORIORETINOPATHY

Perform Topcon OCT (line scan) at first presentation in Eye casualty so the amount of SRF can be compared during follow up visits.

Refer to Medical Retina clinic non-urgently.

Guidelines for all the above conditions is only for Adult patients